

When does a patient have the right to refuse lifesaving medical treatment?

Jay A. Nathanson

Résumé : Étudiant en deuxième année de médecine à l'Université Western Ontario, Jay Nathanson, s'est mérité le troisième prix au concours Logie de dissertation de 1993 du *JAMC*, auquel sont admissibles les étudiants de premier cycle en médecine qui fréquentent une université canadienne. Dans son texte, M. Nathanson analyse les problèmes moraux qui se posent lorsqu'un patient refuse un traitement qui pourrait lui sauver la vie. Il aborde aussi les principes philosophiques de la bienfaisance et du respect de l'autonomie, de même que la question de la capacité du patient dans les décisions relatives au refus de traitement.

When patients need treatment for a life-threatening illness, they usually accept and follow a physician's advice. However, an ethical dilemma can arise if a patient refuses to do this. The physician must then decide whether to abide by the patient's wishes, spend time negotiating and trying to direct the patient toward an acceptable treatment, or disregard the refusal and proceed with the treatment.

Does a right to refuse lifesaving treatment exist? Who possesses this right? And on what basis and under what circumstances can this right be overridden?

Autonomy

Much of our concept of auton-

omy is based on the writings of Immanuel Kant,¹ who believed that people must always be granted rights as autonomous subjects. People must be treated as ends in themselves and never as means to the ends of others. Their capacity for self-determination is all important, for autonomy of the will is "the basis of the dignity of the human." Kant believed that the autonomy of man was based on his rationality and that all autonomous people were worthy of respect. His moral theory is based on the "categorical imperative": "Act only on that maxim whereby thou canst at the same time will that it should become a universal law." Therefore, for an action to be morally acceptable, it must be right for all similar people in similar circumstances.

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An ethical dilemma can arise if a patient refuses to accept and follow a physician's advice about treatment for a life-threatening illness.

Jay Nathanson is a second-year medical student at the University of Western Ontario, London.

The principle of respect of autonomy requires that freedom of action should not be subjected to controlling constraint by others. To respect the autonomy of a person is to recognize that the person is entitled to determine his or her own destiny.²

In the essay *On Liberty*, John Stuart Mill championed the principle of respect for autonomy over all others: "The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."³

Beneficence

The principle of beneficence can be expressed as four hierarchical elements:

- one ought not to inflict evil or harm (the principle of nonmaleficence);
- one ought to prevent evil or harm;
- one ought to remove evil or harm;
- one ought to do good.

Therefore, the principle of beneficence requires, at the very least, that we refrain from deliberately harming others. Also, we should attempt to further the important and legitimate interests of others by preventing or removing possible harm and by doing or promoting good.⁴

Paternalism

The paternalism issue arises when a patient refuses lifesaving treatment recommended by a physician. In this situation, the principle of respect for autonomy is in direct conflict with the principle of beneficence. Paternalism is "... the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interest, or values of the person being coerced."⁵

Therefore, the essence of paternalism is the intentional overriding of the principle of respect for autonomy, based on the principle of beneficence. Recently, the medical and legal communities have witnessed a shift in attitudes toward decision making concerning patient care. In the past, physicians determined appropriate treatment based on what they believed was their patients' best interests. Hippocrates advocated a physician-patient relationship of absolute paternalism: "Perform [these duties] calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition."⁶

Hippocrates thought the physician's primary duty was to the patient's physical well-being, and the patient was assigned a completely passive role. However, Hippocrates disregarded the autonomous patient's capacity for self-determination. This significant ethical shortcoming means his theory of patient care is both outdated and ethically



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unacceptable. Today, the emphasis is on respecting the patient's right to self-determination and capacity for autonomous action.

The role of competence

In a medical and legal setting, patients' competence ultimately determines their right to behave autonomously. Several approaches to determining competence have been suggested.⁷ The "outcome approach" determines competence based on the patient's ability to make decisions that reflect community values. The "status approach" focuses on the patient's physical or mental status. The "functioning approach" is based on the patient's ability to function in decision-making situations.

In this situation, the patient's ability to make decisions is paramount. Therefore, the functioning approach is the most applicable when determining a patient's competence to refuse lifesaving treatment. Using the functioning approach, we can establish four increasingly strict criteria that must be met if a patient is to be considered competent — capable of autonomous behaviour.

- Free action — A person must be capable of action that is intentional, completely voluntary and not the result of coercion, duress or undue influence.

- Authenticity — One must be capable of action that is consistent with one's values, attitudes and life plans. In other words, the person must be acting in character or "authentically." For an action to be considered "unauthentic" it must be unexpected or unusual, no explanation is made in advance, and it must be important in itself or in its consequences. If no explanation is given for an action, the action may not be one the person genuinely wants to make.

- Effective deliberation — A person must realize that a decision has to be made, be aware of the alternatives and their consequences, and be able to make an informed de-

cision based on an informed evaluation. For a decision to be effective it must not be based on ignorance or nonrational weighting of alternatives.

• **Moral reflection** — One must be able to reflect on a set of moral values, accept them and act on them. The person must be capable of rigorous self-analysis, awareness of alternative sets of values, commitment to a method of assessing them, and an ability to put them in place.⁸ This criterion differs from the others in that moral reflection requires questioning of the values on which a decision is based.

To be considered competent, a patient should show the capacity for at least the first three criteria: free action, authenticity and, most important, effective deliberation. Moral reflection, the most stringent of the four criteria, is difficult to assess in a clinical setting. Therefore, if patients exhibit only the capacity for free action, this criterion is not enough to judge them competent. If patients show the capacity for free action as well as authenticity, but clearly are incapable of effective deliberation (or moral reasoning), they will also be judged incompetent.

The right to refuse lifesaving treatment

Currently, competent patients have the right to refuse lifesaving treatment based on the principle of respect for autonomy. The crux of this autonomy-centred approach is that maintenance of the patient's well-being or protection from harm is not enough to justify paternalistic action.⁹ Consequently, once patients exhibit the capacity for autonomous behaviour, they have absolute control with respect to treatment. This is true even if the physician considers the choices made foolish, and even if the refusal of treatment will result in serious harm or death. Mill³ emphasized this autonomy-centred ideal: ". . . the only purpose for which power can be rightfully exercised over any member of a civilized com-

munity, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant."

The patient has the final word as to the course of action treatment will take. Any intervention by the physician must not go beyond vigorous persuasion. The only justified reason for denying an autonomous patient the right to refuse treatment is if the patient's decision will result in harm or death to others.

Why the strict and unyielding emphasis on autonomy? The capacity for autonomous actions is the distinctive characteristic of humans and makes them objects of moral respect. Therefore, according to the current approach on refusal of treatment, to violate the autonomy of a competent person through paternalism is morally impermissible regardless of the circumstances. This is emphasized by Mill's³ observation that paternalistic interventions are "grounded on general presumptions, which may be altogether wrong, and even if right, are as likely as not to be misapplied to individual cases."

The importance of beneficence

This approach to the refusal of lifesaving treatment occupies a middle ground between the absolute paternalism of Hippocrates and the previously discussed autonomy-centred approach. Consequently, it has sometimes been referred to as the holistic approach.⁹ Under it, the physician must balance the competence of the patient against the degree of harm that could be prevented by acting paternalistically. Therefore, paternalism is sometimes justified for competent patients if adherence to their wishes would result in serious physical harm. This approach allows the physician's concern for the patient to play a role in determining treatment.

Discussion

Both the autonomy-oriented and holistic approaches agree that if the patient is fully competent his wishes should be respected. The best-known example involves Jehovah's Witnesses who refuse blood transfusions. If the patient is considered competent, no treatment should be given — the principle of respect for autonomy overrules the principle of beneficence.

Both theories agree that a patient who is declared incompetent does not have the right to self-determination with respect to treatment.¹⁰ In this case, the physician may act paternalistically in order to prevent harm. Because the patient is incapable of autonomous behaviour, the principle of beneficence is followed rather than the principle of respect for autonomy. However, the physician must consider any previous requests with respect to treatment that the patient made while competent.

There is a crucial difference between irreversibly incompetent patients and those whose incompetence is transient. In the case of temporary cognitive disorders caused by delirium related to intoxication, infection, metabolic disorders, tumours, trauma, medication, nutritional deficiencies, extreme depression or anxiety,¹¹ efforts should be made to alleviate the condition so that the patient can again make autonomous decisions.

A conflict between the two approaches arises when patients are considered "borderline incompetent," or their competence is in question. For instance, a patient may meet the criteria for free action and authenticity, but it is unclear whether he is capable of effective deliberation. A problem will arise if this borderline-incompetent patient refuses treatment. The autonomy-centred approach maintains that this patient should be presumed competent and it is the physician's responsibility to prove otherwise. Therefore, paternalism is not morally permissible and the patient has absolute control

over his body. However, the holistic approach asserts that if the patient is borderline competent and much harm can be prevented by paternalistic action, paternalism is morally acceptable. If the refusal concerns a high-benefit, low-risk treatment, the presumption of competence can be overruled by relatively weak evidence of incompetence.

Proponents of the autonomy-centred approach offer several reasons why respect for a patient's autonomy over all other considerations is more pertinent today than ever before. Today, medical care has become increasingly impersonal. Physicians are much less likely to know their patients personally and, therefore, cannot justifiably make decisions based on patients' values. Consequently, the patient, and only the patient, must be in primary control over any decision making regarding treatment.

Although the autonomy-based and holistic approaches both provide advantages, I prefer the holistic approach. It recognizes not only the uniquely human capacity for autonomous action but also the uniquely human capacity for pain and suffering — especially emotional suffering. It also considers the uniquely individualistic nature of every case. The holistic approach attempts to balance the moral weight assigned to preventing human suffering (through the principle of beneficence) against the moral weight assigned to respect for personal autonomy.

This approach also recognizes that during an illness patients experience an existential crisis that impairs their ability to resolve cognitive, affective and social difficulties without the assistance of others.¹² Therefore, according to this approach, the challenge facing the medical community is to reform the medical education system to produce sympathetic and sensitive physicians who can compassionately manage the needs of their patients and have

experience dealing with ethical dilemmas.

Perhaps the strongest argument in favour of the holistic approach is that it allows a physician to err on the side of life and its quality when the competence of a patient is in question. The possible injustice of violating the autonomy of a competent person is outweighed by the immorality of granting an incompetent patient the right to refuse lifesaving treatment.

References

1. Kant I: Cited in Gorovitz S, Macklin R, Jameton AL et al (eds): *Moral Problems in Medicine*, 2nd ed, Prentice-Hall, Englewood Cliffs, NJ, 1983: 14-16
2. Beauchamp TL, Walters L: *Contemporary Issues in Bioethics*, 3rd ed, Wadsworth Publishing, Belmont, Calif, 1989: 29
3. Mill JS: On Liberty. In *Utilitarianism and Other Writings*, Meridian Books, Markham, Ont, 1974: 135
4. Frankena W: Cited in Beauchamp TL, Walters L: *Contemporary Issues in Bioethics*, 3rd ed, Wadsworth Publishing, Belmont, Calif, 1989: 30
5. Mappes TA, Zembaty JS: *Biomedical Ethics*, McGraw-Hill, Toronto, 1986: 33
6. Hippocrates: Cited in Annas GJ, Densberger JE: Competency to refuse medical treatment: autonomy vs. paternalism. *Toledo Law Rev* 1984; 15: 561
7. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Sciences: Cited in Annas GJ, Densberger JE: Competency to refuse medical treatment: autonomy vs. paternalism. *Toledo Law Rev* 1984; 15: 561
8. Miller BL: Autonomy and the refusal of lifesaving treatment. *Hastings Cent Rep* 1981; 11(4): 22-28
9. Ackerman TF, Strong C: *A Casebook of Medical Ethics*, Oxford University Press, New York, 1990: 32
10. The right to refuse treatment: a model act. *Am J Public Health* 1983; 73: 918-921
11. Jonsen AR, Siegler M, Winslade WJ: *Clinical Ethics*, 2nd ed, Collier Macmillan, Toronto, 1986: 54
12. Pellegrino E: Cited in Ackerman TF, Strong C: *A Casebook of Medical Ethics*, Oxford University Press, New York, 1990: 42

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